State of California Department of Consumer Affairs

PHYSICAL THERAPY BOARD OF CALIFORNIA
1418 HOWE AVENUE, SUITE 16, SACRAMENTO, CA 95825-3204
TELEPHONE: (916) 561-8200 FAX: (916) 263-2560

DISABILITY ACCOMMODATION REQUEST FORM FOR EXAMINATION

Alternative Arrangements

The Americans with Disabilities Act (ADA) requires this agency to make "reasonable accommodation" for applicants with disabilities in giving this examination. If you are a person with a disability which may affect your ability to take any portion of the examination, the ADA may require the agency to provide alternative examination arrangements. We are not required to do so if we are unaware of your need for alternatives. We ask that you inform us of any alternative arrangements you may require to take this examination by providing the Board with the information requested below. This information and any documentation regarding your disability and your need for accommodation in testing will be considered strictly confidential; however, your signature on this form is authorization for the release of this information to the provider of the national examination to document the need for an accommodation. If you require instructions for the evaluators, please visit our website at www.ptb.ca.gov or contact our office to have the instructions mailed to you.

Name: _____

Address: _____

Phone: ( ) _____ SS# ___ - ___ - ____

Please respond to the following three questions. Attach additional sheets as needed.

My disability is (e.g., visual impairment, arthritis, etc.):

_____

_____

_____

My disability impairs my ability to accurately exhibit my knowledge and skill under standardized examination conditions in the following way:

_____

_____

_____

The accommodation I am requesting is (please be specific):

_____

_____

NOTE: If the requested accommodation involves additional time for the examination, please indicate the amount of additional time required.

Verification by a professional, licensed to perform a diagnosis and provide treatment of the disability, must be completed on the reverse side of this form.

SOME ACCOMMODATION REQUESTS MAY REQUIRE ADDITIONAL DOCUMENTATION

I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct. I authorize the Physical Therapy Board of California to contact and discuss the information provided by the professional who has completed the reverse side of this form.

Signed: _____ Date: _____

(For State use only. Do not mark below this line.)
Rev 04/03 PM6.5

Application Reviewer _____

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PROFESSIONAL VERIFICATION OF NEED FOR ACCOMMODATION

_____ , a candidate for examination by the Physical Therapy Board of California, has made a request for accommodation of disability. The request is described on the reverse side of this form.

The purpose of this form is to request your professional opinion concerning the disability and the accommodation requested. Please read the instructions for this form and answer the questions below and sign the certification. The opinion you provide will be used in evaluating the request.

The information obtained on this form will be treated as a confidential medical record except that exam proctors and exam providers may be informed regarding necessary modifications to exam procedures, and first aid and safety personnel may be informed, when appropriate, if the disability might require emergency treatment.

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Please provide your diagnosis, the nature and extent of the candidate's disability and, if applicable, the tests used to diagnose the disability (attach additional sheets if needed).

_____

_____

_____

What effect does the disability and/or medical condition have on the candidate's ability to perform under standardized testing conditions?

_____

_____

_____

In your opinion what examination accommodation, if any, does this candidate require?

_____

_____

_____

This is a ☐ permanent ☐ temporary disability.

If this is a temporary disability, please indicate anticipated end of disability. _____

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I certify under penalty of perjury under the laws of the State of California that I have the necessary specialized training and am currently licensed as specified below, or may legally diagnose based on my employment by the institution named below, to make the above diagnosis, that I personally examined the candidate named above, and that the above diagnosis and assessment of accommodation request is my professional judgment. I understand the candidate has authorized me to provide the information on this form, and to provide further information if necessary. The board may also obtain an independent assessment by a second professional.

_____
Signature of Professional Date

_____
Typed or Printed Name of Professional

_____
Title

_____
License Number

_____
Name of Institution or Practice

_____
Street Address

_____
City, State, ZIP Code

( )
_____
Telephone Number